| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155659 | A. BUILDING _____ B. WING _____ | C 10/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SELLERSBURG HEALTHCARE CENTER | 7823 OLD HWY # 60 SELLERSBURG, IN 47172 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00389250, IN00391148, IN00392794, IN00392927 and IN00392996.<br><br>Complaint IN00389250 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00391148 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00392794 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00392927 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00392996 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey dates: October 25, 26 and 27, 2022<br><br>Facility number: 010613<br>Provider number: 155659<br>AIM number: 200221040<br><br>Census Bed Type:<br>SNF/NF: 94<br>Total: 94<br><br>Census Payor Type:<br>Medicare: 11<br>Medicaid: 68<br>Other: 15<br>Total: 94<br><br>Sellersburg Healthcare Center was found to be in compliance with 42 CFR Part 483, Subpart B and | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155659 | A. BUILDING _____ B. WING _____ | C 10/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SELLERSBURG HEALTHCARE CENTER** | **7823 OLD HWY # 60 SELLERSBURG, IN 47172** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 1<br>410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00389250, IN00391148, IN00392794, IN00392927 and IN00392996.<br><br>Quality review completed on October 30, 2022. | F 000 | | |